c. Allowable central office or home office costs must be allocated to individual provider sites under a reasonable and consistent basis which reflects the number of encounters and the utilization costs of each category of ambulatory services at each site. The worksheets and method of allocation to each site must also be available upon the Department's Medical Assistance Unit request.

x. Interim Payment Rates - The encounter rate for each FQHC site will be determined on the information which best estimates the reasonable costs of services for a fiscal period. Ambulatory services not included in the definition of an encounter will be reimbursed, subject to the restrictions on the number or type of services allowed to any recipient as a Medical Assistance benefit, during the interim before cost settlement according to fee schedules on file for the services provided.

a. Interim encounter rates should reflect the total estimated Medicaid costs of core services, plus or minus any difference between the Department's Medical Assistance Unit interim fee-for-service payments and the reasonable costs of other ambulatory services divided by the total number of anticipated Medicaid encounters.

b. Rate adjustments may be requested by the provider no more than twice in each provider's fiscal year. Rate adjustment requests must be specific as to the amount in question, and be accompanied by information which supports the provider's request which includes, but is not limited to, audited or interim financial statements, budget data, management information data, pro-forma cost reports, patient utilization data and costs of new services or equipment, or specific information the Department's Medical Assistance Unit requests.

xi. Cost Settlements - The Department's Medical Assistance Unit will issue Interim and Final Cost Settlements based on the Medicaid cost report issued by the Department's Medical Assistance Unit.

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2. c. FQHC (continued)

a. Within sixty (60) days of receipt of an FQHC provider's unaudited cost report, the Department's Medical Assistance Unit will review the cost report submitted, not withstanding any appropriate adjustments the Department's Medical Assistance Unit may make, in order to issue a tentative settlement to reimburse the FQHC for any underpayment or recover any overpayment for the fiscal period to be settled.

b. Within thirty (30) days after each provider's audited cost report is finalized by the Department's Medical Assistance Unit agent, the Department's Medical Assistance Unit will reimburse an FQHC for any underpayments or recover any overpayments made for fiscal period represented in the audited cost report.

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3. Other Laboratory and Radiology Services - The maximum allowable fees for such services do not exceed reasonable charges established by Medicare (Part B). Payment for clinical diagnostic laboratory tests rendered by independent laboratories will not exceed Medicare's fee schedule for non patients. Exceptions included in Section 2303(d) of the Deficit Reduction Act will be paid at a rate not to exceed the Department's Medical Assistance Unit fee schedule.

4. a. Nursing Facility Services for Individuals Over 21 Years of Age - Refer to Attachment 4.19-D.

b. Special Services Under EPSDT - The State will use the reimbursement methods discussed in this attachment for services in excess of program limitations. These are as follows:

i. Ambulatory Services	Section of Attachment 4.19-B
a. Emergency Room Visits over 6/yr	Section 2a
b. Physician Psychiatrist Evaluation and Psychotherapy	Section 5a
c. Home Health Visits	Section 7
d. Physical Therapy	Section 11a
e. Rehabilitation Services - Developmental Disability Centers	Section 13d
f. Clinic Services	Section 9
g. Case management - (Same method as currently used for PCS Case Management)	Section 19
h. Nutritional Services	Section 20
i. Drugs	Section 12
j. Oxygen and Related Equipment	Section 7c
k. Personal Care Services	Section 24f
l. Eyeglasses	Section 12d
m. Dental	Section 10
n. Hearing Aids	Section 12c
o. Substance Abuse	Section 1,2 and 9

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ii. Inpatient Services — Attachment 4.19-A

a. Substance Abuse — Attachment 4.19-A

b. Organ Transplants — Attachment 4.19-A

iii. EPSDT Private Duty Nursing Services - are reimbursed by way of the lowest of the provider's actual charge for the services; or the maximum allowable charge for that service as established by the Department's Medical Assistance Unit pricing file.

iv. EPSDT Respiratory Care Services - are reimbursed on a fee schedule established by the Department's Medical Assistance Unit, or the provider's usual and customary charges, whichever is less.

c. Family Planning Services - The Department's Medical Assistance Unit upper limit for reimbursement is the lower of:

i. The family planning providers' actual charge; or

ii. The allowable charge as established by the Department's Medical Assistance Unit fee schedule.

iii. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. Contraceptives requiring a prescription are payable subject to attachment 4.19-B section 12.A prescription drugs. Payment for oral contraceptives is limited to purchase of a three (3) month supply. Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost.

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5. a. Physicians – The Department's Medical Assistance Unit upper limit for reimbursement is the lower of: The physician's actual charge for a service; or

   i. The maximum allowable charge as established by the Department's Medical Assistance Unit fee schedule; if the service or item does not have a specific price on file the provider must submit documentation to the Department and reimbursement will be based on the documentation; or
   ii. The Medicare fee schedule for non patients for clinical diagnostic laboratory tests; or
   iii. For the exceptions in Section 2303 (d) of the Deficit Reduction Act – the Department's Medical Assistance Unit fee schedule.

BREAK IN PAGE NUMBER

Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT	Procedure Code	SFYE MAXIMUM PAYMENT
59000	$52.71	59852	$729.50	99401	$10.19
59012	$140.64	59855	$351.58	99402	$20.38
59015	$74.72	59856	$527.38	99403	$30.57
59020	$51.84	59857	$641.65	99404	$40.76
59025	$37.23	59870	$290.07	99411	NA
59030	$47.19	59899	BY REPORT	99412	NA
59050	$70.08	99201	$27.63	99420	NA
59051	$61.53	99202	$38.19	99429	BY REPORT
59100	$729.07	99203	$49.42	99432	$75.43
59120	$729.07	99204	$66.52	90700	$23.00
59121	BY REPORT	99205	$77.62	90701	$17.23
59130	$541.41	99211	$22.17	90702	$6.33
59135	$878.41	99212	$28.47	90703	$4.00
59136	$860.44	99213	$33.26	90704	$18.25
59140	BY REPORT	99214	$44.36	90705	$17.55
59150	$527.38	99215	$66.52	90706	$17.55
59151	$729.07	99241	$39.10	90707	$35.00
59160	$219.60	99242	$51.37	90708	$22.30
59200	$57.13	99243	$61.24	90709	$23.32
59300	$133.79	99244	$86.91	90710	NA
59320	$123.06	99245	$114.57	90711	$33.00
59325	$193.37	99271	$37.93	90712	$16.22
59350	$729.07	99272	$47.40	90713	$18.00
59400	$1,191.12	99273	$61.63	90714	$3.00
5940P	$1,103.89	99274	$85.34	90716	$46.00
59409	$667.19	99275	$112.46	90717	$38.00
59410	$776.14	99341	$38.86	90719	$5.00
59412	$196.32	99342	$47.40	90720	$38.00
59414	$175.79	99343	$61.63	90721	$45.00
59425	$230.90	99351	$26.60	90724	$8.00
59426	$318.13	99352	$39.11	90725	$5.00
59430	$112.52	99353	$52.15	90726	$185.00
59510	$1,441.40	99354	$63.22	90727	$4.00
5951P	$1,354.18	99355	$31.61	90728	$5.00
59514	$1,072.34	99358	NA	90730	$63.00
59515	$1,164.22	99359	NA	90732	$15.00
59525	$393.37	99381	$54.05	90733	$11.00
59812	$206.23	99382	$54.05	90737	$18.68
59820	$353.90	99383	$54.05	90741	BY REPORT
59821	$346.56	99384	$66.59	90742	BY REPORT
59830	$219.69	99391	$37.39	90744	$26.00
59840	$325.22	99392	$37.39	90745	$42.00
59841	$448.28	99393	$40.81	90749	BY REPORT
59850	$404.31	99394	$54.53	Q0158	$35.85
59851	$404.31				

#97-005 app: 6/4/97 eff: 7/1/97
96-003

5. a. v. Adequacy of Access. Data obtained from a survey of physician and nurse practitioner charges billed to Medicaid was compiled and analyzed by a Medical Assistance departmental work group. Provider participation (as defined below) has not less than 90% in any of the specialties measured. MMIS output reports are included herewith as documentation.

The attached MMIS outputs document minimum participation rates in any of the reporting quarters included as shown below:

For:	Obstetricians:	100%
	Pediatricians:	90%
	Family and General Practitioners:	100%

Participation for the purpose of this analysis is defined as having treated a minimum of five different recipients, and provided a minimum of ten services and billed charges of at least $200.00, and provided a minimum of fifteen units of service in any quarter reported as "participating."

To comply with the data requirements addressed in the Federal Register of October 3, 1994, page 50237 and 50238, HCFA can be assured that the minimum of $14.34 is allowed for any vaccine administered, because a brief office visit (99211), which allows $22.24, is the least service compensated.

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app: 6/4/97 eff: 7/1/97

5. a. vi. Adequacy of Access - Pediatrics: Analysis of MMIS provider participation for designated provider classes indicate the maximum allowed fees in effect since 7/1/96 were successful in providing recipients' access. The maximum allowed fees submitted for effect 7/1/97 are expected to be more than adequate to assure access equal to that obtained by the general public. Analysis of charge data for the most recently completed 12 month period was completed for confirmation purposes.

#97-005 app: 6/4/97 eff: 7/1/97

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5. a. vii. Inflation Adjustment, per new section of Idaho Code, Chapter 1, Title 56, Section 136: (1) Beginning with fiscal year 1996, the rate of reimbursement for all Medicaid-covered physician services rendered to Medicaid recipients shall be adjusted each fiscal year. Each fiscal year adjustment shall be determined by the Director, and shall equal the year over year inflation rate forecasted as of the midpoint of the fiscal year by the index of all items, goods and services in the pacific northwest as published by Data Resources Incorporated. Such forecast index shall be the last published forecast prior to the start of the fiscal year, provided, however, an adjustment may exceed the index rate sited in this section at the discretion of the Legislature.